EFFECTIVE

October 1, 2011

Subject

DHS-1171, Assistance Application

RFF 1171

RFF 1171 is updated with the new version of the DHS-1171, Assistance Application. Previous editions are obsolete.

Local offices must distribute the new applications only after September 30, 2011. However, if a client submits an earlier version of the application, it must be accepted to preserve the application date. A new application must be completed by either the client or the worker depending on the mode in which the interview is held.

Reason: The application is updated with new October policy.

Communication Plan: What's New.

EXHIBIT (PAGE 1)

Assistance Application

Michigan Department of Human Services (DHS)

Instructions

- ***If you answer all the questions on the assistance application, we can determine if you are eligible for ALL programs. Please print your answers.***
- ***Check ALL programs you are applying for.*** *The program symbols below will appear in each section of questions on the application. These symbols tell you which questions you must answer for each program. For more information about programs, see the* ***Information Booklet****.*

☐ **Food Assistance Program (FAP).**

☐ **Medical Assistance (MA, AMP)** (doctor or hospital bills, prescriptions, Medicare premiums).
Retroactive Medical - Do you, or anyone in your household, have paid or unpaid medical expenses in the last three months? ☐ Yes ☐ No

☐ **Child Development and Care (CDC)** (help with child care payments).

☐ **Cash Assistance (FIP - Family Independence Program, RAP - Refugee Assistance Program, SDA - State Disability Assistance)** (help with cash for pregnant women, families with children, refugees, adults with disabilities, live-in caretakers of adults with disabilities or residents of special living arrangements).

☐ **State Emergency Relief (SER)** (utility shut-off, eviction notice, burial or other emergency).
NOTE: You must complete both the assistance application and SER supplemental application (DHS-1514) available from the DHS office in your area or you may also apply online at *www.michigan.gov/dhs-forms*.

If you cannot complete this application now, you may complete the filing form on the last page of the information booklet or online at *www.michigan.gov/dhs-forms*. The date DHS receives your assistance application or filing form may affect the date your benefits start. DHS will still need to receive your completed assistance application before any benefits can be approved.

If you need help filling out this application, DHS must help you. If you are refused help, you may call (855) 275-6424.

1. If you do not speak English or you have a disability, how can we help you?
   ☐ Interpreter ☐ Sign language ☐ Assisted listening device (ALD) ☐ Other _____
2. If you do not speak English, what language do you speak? _____

Si usted necesita ayuda llenando esta solicitud, DHS debe ayudarle. Si ellos se niegan ayuda, usted puede llamar a (855) 275-6424.

1. ¿Si usted no habla inglés o tiene una incapacidad, como podemos ayudarle?
   ☐ Intérprete ☐ Dactilología ☐ Dispositivo vivo asistido (ALD) ☐ Otro _____
2. ¿Si usted no habla inglés, qué idoma habla? _____

إن كنت تتطلّب إلى مساعدة في ملء هذا الطلب، فيجب على DHS تقديم المساعدة لك. وفي حال تمّ رفض تقديم المساعدة لك، فيمكنك الاتصال بالرقم ٣٧٣-٠٧٠٧ (٥١٧)

١. إن كنت لا تتكلم اللغة الإنكليزية أو تعاني من إعاقة، فكيف يمكننا مساعدتك؟
☐ مترجم شفهي ☐ لغة إشارة ☐ أجهزة مساعدة للسمع (ALD) ☐ غير ذلك _____

٢. إن كنت لا تتكلم اللغة الإنكليزية، فما هي اللغة التي تتكلمها؟_____

For office use only	Date application received in local office	Case name	
		Application number	Case number
		Specialist name	
		Specialist phone	Fax
		Specialist email	

This form is issued under authority of the Code of Federal Regulations (CFR) 42 CFR 435.907; 7 CFR 273.2(d); and Sections 25 and 59 of Act 280 of the Public Acts of 1939, as amended, and Public Act 280 of 1939. You must complete this form if you want the department to consider your application for financial, medical or food assistance or for child care services.

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EXHIBIT (PAGE 2)

A. Address Information

1. **Check where you live:** ☐ House/apartment/mobile home ☐ Homeless ☐ Other _____

If you live in a facility or special living arrangement, or have lived in one in the last three months, check what type below:

☐ Home for the aged	☐ Hospital	☐ Jail/prison	☐ Juvenile residential facility
☐ Children's group home	☐ County infirmary	☐ Emergency housing/shelter	☐ Community justice center
☐ Adult foster care home	☐ Nursing facility		☐ Domestic violence shelter
☐ Commercial boarding house	☐ Mental health or psychiatric facility	☐ Drug or alcohol treatment center	☐ Halfway house
			☐ Assisted living

What date do you expect to leave, or what date did you leave the facility? ☐☐/☐☐/☐☐☐☐ ☐ Date unknown ☐ Does not apply

Name of facility _____

2. **Address where you live, or address of facility** (number, street, rural route, apartment/lot number)

City | State | Zip code | County

3. **Mailing address** (if different from above, or PO box)

City | State | Zip code | County

4. Home phone ☐☐☐-☐☐☐-☐☐☐☐ Cell phone ☐☐☐-☐☐☐-☐☐☐☐ Work phone ☐☐☐-☐☐☐-☐☐☐☐

Phone number where we can leave a message ☐☐☐-☐☐☐-☐☐☐☐ Whose number is it? (name/relationship)

Telephone Typewriter (TTY) number ☐☐☐-☐☐☐-☐☐☐☐ Email address

5. Have you moved from, or received assistance from another state any time after August 1996? ☐ Yes ☐ No

If yes, what state? _____ What county? _____

Date you moved to Michigan (MI) ☐☐/☐☐/☐☐☐☐ What was your caseworker's name? Caseworker phone number ☐☐☐-☐☐☐-☐☐☐☐

6. Do you and your household intend to remain in MI? ☐ Yes ☐ No

7. Did you or someone in your household come to MI with a job commitment or looking for work? ☐ Yes ☐ No

8. If you are a migrant or seasonal farmworker, list your permanent mailing address below.

Permanent mailing address (number, street, rural route, apartment/lot number, PO box)

City | State | Zip code | County

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EXHIBIT (PAGE 3)

B. Food Assistance Information

1. Does everyone in the household buy food and fix or eat meals together? ☐ Yes ☐ No
   If no, list who does not _____
2. How much are the total cash assets belonging to your household?
   (Include cash, savings, checking, savings bonds, etc.) $_____
3. How much is the total monthly gross income (before any deductions) for your household?
   (Include earnings, unemployment benefits, child support, Social Security benefits, etc.) $_____
4. Does anyone in your household receive tribal food distribution benefits? ☐ Yes ☐ No
   If yes, list who _____

C. Information About You and Your Household

- ***Answer for ALL persons in your household (everyone living in your home). Include persons who are not there all the time, even if you are not applying for them. LIST YOURSELF FIRST.***
- ***If you are an alien with a sponsor who has agreed to financially support you, even if (s)he is not doing so, include your sponsor's information in one of the boxes below.***
- ***If you are filling out the application for a patient in a nursing facility, list:***
  - ***The patient first.*** - ***The patient's spouse.*** - ***Any dependents living at home.***
- ***Spaces for five more persons in your household are available on the next five pages. Do you need more household pages? ☐ Yes ☐ No***

Answer for person 1. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth ___/___/_____ 3. Relationship to you SELF
4. ☐ Male ☐ Female 5. Social Security number* ___-___-_____ * (optional if applying ONLY for child care or emergency medical services)
6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated
7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
   Mother's Maiden Name _____ Place of Birth _____ (county, city, state)
8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▶ Due date/pregnancy end date ___/___/_____
   Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____
9. Highest grade completed in school _____ ☐ Received GED
10. In school now? ☐ Yes ☐ No If yes, ▶ School name _____ ☐ Full-time ☐ Half-time ☐ Less than half-time
    ☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other
11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino
12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
    ☐ Asian ☐ Black/African American
    ☐ Native Hawaiian/Other Pacific Islander ☐ White
13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
    ☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
    ☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person
14. If this person is currently away from the home ▶ Why? _____ Expected return date _____
15. How many days each month does this person stay at the application address? ____ at another address? ____
    Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)
16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
    ☐ Family Planning Services ☐ Child care ☐ Cash assistance ☐ None (not applying)

**Applies to FIP, Medicaid and RAP applicants only

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EXHIBIT (PAGE 4)

Answer for person 2. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) 2. Date of birth 3. Relationship to you

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father	**Mother**
Name (first, mi, last) Birthdate SSN	Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____	_____ __/__/____ _____
Approximate age (if Birthdate not known): _____	Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No	Is she in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No	Is she deceased ☐ Yes ☐ No
Is he the same father described for a previous child? ☐ Yes, name: _____ ☐ No	Is she the same mother described for a previous child? ☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No	Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No	Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:	If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?	Is there a support order naming her for this child?
Order # _____ County_____State_____Country_____	Order #_____County_____State_____Country_____
Last known employer & address _____	Last known employer & address _____
Month/year last worked __/____	Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____	Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)	Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander	☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White	☐ Black/African American ☐ White
Father's health insurance covering this child:	Mother's health insurance covering this child:
Carrier _____ Policy # _____	Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

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EXHIBIT (PAGE 5)

Answer for person 3. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) 2. Date of birth 3. Relationship to you

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father	**Mother**
Name (first, mi, last) Birthdate SSN	Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____	_____ __/__/____ _____
Approximate age (if Birthdate not known): _____	Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No	Is she in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No	Is she deceased ☐ Yes ☐ No
Is he the same father described for a previous child? ☐ Yes, name: _____ ☐ No	Is she the same mother described for a previous child? ☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No	Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No	Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:	If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?	Is there a support order naming her for this child?
Order # _____ County_____State_____Country_____	Order #_____County_____State_____Country_____
Last known employer & address _____	Last known employer & address _____
Month/year last worked __/____	Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____	Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)	Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander	☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White	☐ Black/African American ☐ White
Father's health insurance covering this child:	Mother's health insurance covering this child:
Carrier _____ Policy # _____	Carrier _____ Policy # _____

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EXHIBIT (PAGE 6)

Answer for person 4. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) 2. Date of birth 3. Relationship to you

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father	**Mother**
Name (first, mi, last) Birthdate SSN	Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____	_____ __/__/____ _____
Approximate age (if Birthdate not known): _____	Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No	Is she in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No	Is she deceased ☐ Yes ☐ No
Is he the same father described for a previous child? ☐ Yes, name: _____ ☐ No	Is she the same mother described for a previous child? ☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No	Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No	Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:	If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?	Is there a support order naming her for this child?
Order # _____ County_____State_____Country_____	Order #_____County_____State_____Country_____
Last known employer & address _____	Last known employer & address _____
Month/year last worked __/____	Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____	Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)	Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander	☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White	☐ Black/African American ☐ White
Father's health insurance covering this child:	Mother's health insurance covering this child:
Carrier _____ Policy # _____	Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

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EXHIBIT (PAGE 7)

Answer for person 5. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) 2. Date of birth 3. Relationship to you

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father	**Mother**
Name (first, mi, last) Birthdate SSN	Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____	_____ __/__/____ _____
Approximate age (if Birthdate not known): _____	Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No	Is she in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No	Is she deceased ☐ Yes ☐ No
Is he the same father described for a previous child? ☐ Yes, name: _____ ☐ No	Is she the same mother described for a previous child? ☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No	Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No	Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:	If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?	Is there a support order naming her for this child?
Order # _____ County_____State_____Country_____	Order #_____County_____State_____Country_____
Last known employer & address _____	Last known employer & address _____
Month/year last worked __/____	Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____	Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)	Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander	☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White	☐ Black/African American ☐ White
Father's health insurance covering this child:	Mother's health insurance covering this child:
Carrier _____ Policy # _____	Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

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EXHIBIT (PAGE 8)

Answer for person 6. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) 2. Date of birth 3. Relationship to you

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father	**Mother**
Name (first, mi, last) Birthdate SSN	Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____	_____ __/__/____ _____
Approximate age (if Birthdate not known): _____	Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No	Is she in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No	Is she deceased ☐ Yes ☐ No
Is he the same father described for a previous child? ☐ Yes, name: _____ ☐ No	Is she the same mother described for a previous child? ☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No	Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No	Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:	If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?	Is there a support order naming her for this child?
Order # _____ County_____State_____Country_____	Order #_____County_____State_____Country_____
Last known employer & address _____	Last known employer & address _____
Month/year last worked __/____	Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____	Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)	Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander	☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White	☐ Black/African American ☐ White
Father's health insurance covering this child:	Mother's health insurance covering this child:
Carrier _____ Policy # _____	Carrier _____ Policy # _____

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EXHIBIT (PAGE 9)

D. Household Members Under Age 22

Do you need more pages? ☐ *Yes* ☐ *No*

List person(s) under age 22 in the household	List name of mother/father (first, middle, last)	Check if parent is deceased	If person under age 22 does not live with a parent, who do they live with?	Check box(es) below if: • Parents were ever married to each other. • Paternity was legally established. • Support is court-ordered.
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ____________
	Father	☐ Yes	Relationship	

DHS-1171 (Rev. 10-11) Previous edition obsolete. I

EXHIBIT (PAGE 10)

E. Child Development and Care (CDC) Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. Do you need help paying for child care? ☐ **Yes** ▶ ***Check why and complete the table below.*** ☐ **No**

☐ Work ☐ High school or GED ☐ Education/training approved by DHS or the work participation program.

☐ Treatment for health or social condition (explain)____________________________

Name of child needing care	Provider name	Provider ID number (if known)	What time is child in care? Example: 8:00 a.m. - 4:00 p.m.
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______
			Su ______ Wed ______ M ______ Thurs ______ Tu ______ Fri ______ Sat______

DHS-1171 (Rev. 10-11) Previous edition obsolete. J

EXHIBIT (PAGE 11)

F. Medical Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. List anyone in your household who is a victim of domestic violence _____ ☐ None
2. List any children under six years of age who are not up-to-date on their immunizations (shots) _____ ☐ None
3. List any children in an *Early On*® program _____ ☐ None

   Name and phone number of *Early On* coordinator _____
4. List any children who receive Children's Special Health Care Services _____ ☐ None
5. List anyone who is now or has ever been in a special education class _____ ☐ None

   Name and phone number of school _____
6. List anyone going to an alcohol or drug treatment program _____ ☐ None
7. List anyone working with Michigan Rehabilitation Services _____ ☐ None

   Name and phone number of Michigan Rehabilitation counselor _____
8. List anyone caring for a child, spouse or other person with a disability in the home _____ ☐ None
9. Is the caregiver able and available to work in addition to caring for someone? ☐ Yes ☐ No
10. **List anyone applying for assistance who is physically or mentally unable to work full-time.** ☐ **None**

Person	Medical condition	Is this person able to work?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

G. Medical Coverage

Does anyone in your household have, or expect to have, medical coverage (other than Medicaid)?

☐ **Yes** ▶ ***Check which type of coverage and complete the table below.*** ☐ **No**

☐ Health/hospital insurance (employer, parent, etc.) ☐ Accident (home or car insurance, etc.) ☐ Workers' compensation
☐ Medicare ☐ MIChild ☐ Health savings account
☐ Plan/contract (life care contract, etc.) ☐ Other _____

Person covered	Name and address of insurance company	Claim, contract/group numbers, effective date

DHS-1171 (Rev. 10-11) Previous edition obsolete. K

EXHIBIT (PAGE 12)

H. Asset Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in your household have any assets? (include assets owned with another person)

☐ **Yes** ▸ ***Check all types of assets your household has and complete the table below.*** ☐ **No**

☐ Checking accounts
☐ Certificates of deposit (CD)
☐ Cash on hand/in safe deposit box
☐ Trust or annuities
☐ Life estate
☐ Life insurance
☐ Burial trust/funeral contract(s)
☐ Savings accounts
☐ Credit union accounts
☐ Money market accounts
☐ Christmas club accounts
☐ Savings bonds, stocks or mutual funds
☐ Land contract, mortgage or other notes payable to household member
☐ Burial plot(s), casket, etc.
☐ Other (mineral/water/oil rights, etc.)
☐ Patient trust fund
☐ IRA, KEOGH, 401K or deferred compensation account(s)
☐ Real estate/property
☐ Real estate/property (not including place you live)
☐ Tools and equipment, livestock or crops
☐ Lottery/Gambling winning

Owner of asset	Type of asset	Balance (amount or value)	Name and address (bank, insurance company, etc.)	Account or policy number, etc.

2. Has anyone in your household:

- Sold/given away property, land, stocks, bonds, vehicles, savings, checking or credit union accounts, income, cash, etc., or closed any accounts or removed or added a name to any asset within the last 60 months? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date __/__/____ ▸ How much? $
- Filed a lawsuit which may bring money, property, etc.? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date __/__/____ ▸ How much? $
- Received a one-time payment (such as worker's compensation, lottery winnings, insurance settlement lawsuit award, etc.) within the last 60 months (five years)? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date __/__/____ ▸ How much? $
- Acting for another household member put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device within the last 60 months (five years)? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date __/__/____ ▸ How much? $

I. Vehicle Information

Do you need more pages? ☐ *Yes* ☐ *No*

Does anyone in your household have any vehicles?

☐ **Yes** ▸ ***Check all that apply and complete the table below.*** ☐ **No**

☐ Car ☐ Truck ☐ Boat ☐ Camper/trailer ☐ Motorcycle ☐ RV ☐ Other vehicles

Owner(s) on vehicle title or registration	Year	Make / Model	Mileage	Amount owed

DHS-1171 (Rev. 10-11) Previous edition obsolete. L

EXHIBIT (PAGE 13)

J. Migrant or Seasonal Farmworker Income

Do you need more pages? ☐ *Yes* ☐ *No*

Is anyone in your household a ☐ **migrant or** ☐ **seasonal farmworker?**
☐ **Yes** ▸ ***Complete the table below.*** ☐ **No**

		Date	Gross pay amount
Has anyone received any income from the same grower within 30 days before the application date?	☐ Yes ▸ Name of person(s): ☐ No		
Does anyone expect to receive more income this month?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone received a travel advance?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone recently lost their only source of income?	☐ Yes ▸ Name of person(s): ☐ No	Last pay date	Gross pay amount

K. Employment Changes

Do you need more pages? ☐ *Yes* ☐ *No*

Did anyone in your household have changes in employment in the last 30 days?
☐ **Yes** ▸ ***Check all that apply and complete the table below.*** ☐ **No**

Check all that apply	Name of person(s)	Name and address of employer	Date of change	Date and gross amount of final pay
☐ Refused work Reason _____				
☐ Voluntarily reduced hours worked Reason _____				
☐ Quit a job Reason _____				
☐ Was laid off Reason _____				
☐ Was fired Reason _____				
☐ Is participating in a strike Reason _____				

L. Self-Employment Income (including odd jobs)

Do you need more pages? ☐ *Yes* ☐ *No*

1. Is anyone in your household self-employed or will anyone be self-employed before the end of the next calendar month? ☐ **Yes** ▸ ***Complete the table below.*** ☐ **No**

Self-employed person	Type of work or business and date business started	Business name and address	Gross monthly income (amount before any expenses)	Monthly self-employment expenses
	☐☐/☐☐/☐☐☐☐			
	☐☐/☐☐/☐☐☐☐			

DHS-1171 (Rev. 10-11) Previous edition obsolete. M

EXHIBIT (PAGE 14)

M. Employment Income

Do you need more pages? ☐ *Yes* ☐ *No*

Is anyone in your household working for wages or salary or will anyone begin working before the end of the next calendar month? ☐ **Yes** ▶ ***Complete the information below for each working person.*** ☐ **No**

Name of working person _____ Start date ___/___/____

Employer name/address/phone number _____

Type of work _____ Job title _____

If new job, first pay check date ___/___/____ Will employment continue? ☐ Yes ☐ No

Day of week pay is received _____ Most recent or last pay check date ___/___/____

Average # of hours expected to work _____ per ☐ Week ☐ Pay period Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive a ☐ Bonus ☐ Commission or ☐ Overtime? ☐ Yes ☐ No

▶ If yes, amount $ _____ How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▶ If yes, average tips not included $ _____ per ☐ Week ☐ Pay period ☐ Other _____

Name of working person _____ Start date ___/___/____

Employer name/address/phone number _____

Type of work _____ Job title _____

If new job, first pay check date ___/___/____ Will employment continue? ☐ Yes ☐ No

Day of week pay is received _____ Most recent or last pay check date ___/___/____

Average # of hours expected to work _____ per ☐ Week ☐ Pay period Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive a ☐ Bonus ☐ Commission or ☐ Overtime? ☐ Yes ☐ No

▶ If yes, amount $ _____ How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▶ If yes, average tips not included $ _____ per ☐ Week ☐ Pay period ☐ Other _____

DHS-1171 (Rev. 10-11) Previous edition obsolete. N

EXHIBIT (PAGE 15)

N. Other Income

Do you need more pages? ☐ *Yes* ☐ *No*

1. **Does anyone in your household receive, or expect to receive (has applied for), any income other than earnings?**
   ☐ **Yes** ▶ ***Check all boxes that apply and complete the table below.*** ☐ **No**

☐ Social Security benefits (RSDI) ☐ Supplemental Security Income (SSI) ☐ Disability benefits
☐ Pension/retirement benefits ☐ Resettlement Income (FAP only) ☐ Unemployment benefits
☐ Railroad retirement benefits ☐ Workers' compensation ☐ Rental income
☐ Veterans benefits ☐ Money from friends or relatives, etc. ☐ Room and/or board income
☐ Military allotments ☐ Interest/dividend income
☐ Land contract, mortgage or other notes payable to a household member
☐ Income/payments from a tribe (tribal general assistance, land claims, casino profit sharing, per capita, etc.)
☐ Other (mineral/water/oil rights, etc.) ☐ Child support/court order docket # _____

Person receiving/ expecting money	Income source/type	How often received	Amount received	Expected to continue?	Date expecting if not yet received
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

2. **If anyone in your household receives Social Security (RSDI) or Railroad Retirement benefits, list the claim number(s)** _____

3. **Is anyone in your household a veteran?** ☐ Yes ☐ No If yes, is person a:
   ☐ **U.S. veteran with a disability. Who?** _____
   ☐ **Widow(er) or child of a deceased U.S. veteran? Who?** _____
   ☐ **Spouse or child with a disability of a U.S. veteran with a disability? Who?** _____
   ☐ **None of these**

Has anyone in your household applied for VA health care benefits? ☐ Yes ☐ No **Who?** _____

Is anyone in your household receiving VA health care benefits? ☐ Yes ☐ No **Who?** _____

DHS-1171 (Rev. 10-11) Previous edition obsolete. O

EXHIBIT (PAGE 16)

O. Disability Benefits

Do you need more pages? ☐ *Yes* ☐ *No*

1. Has anyone in your household, who is not receiving disability benefits, applied for or been denied disability benefits? ☐ **Yes** ▶ ***Check all disability benefits that apply and complete the table below.*** ☐ **No**

Person	Type of benefit	Benefit status	Date of action (if known)
	☐ Social Security Claim # ____ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other____	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	
	☐ Social Security Claim # ____ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other____	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	
	☐ Social Security Claim # ____ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other____	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	

* *Social Security Administration has decided they are not disabled.*

2. If benefits were denied, have the person's health problem(s) changed? ☐ **Yes** ☐ **No**

If yes, ▶ **List who** ____ **Date of change** ____

☐ **Health problem is worse** ☐ **New health problem** ☐ **Has more than one health problem**

P. Dependent Care Expenses and Court-Ordered Support

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in work, school, or training pay for the care of a ☐ **child,** ☐ **family member with disabilities?** ☐ **Yes** ▶ ***Complete the table below (DO NOT include amounts paid by DHS or anyone else).*** ☐ **No**

Person paying	Amount paid	How often	Name of person(s) receiving care
	$ ____	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	
	$ ____	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	
	$ ____	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	

2. Does anyone in your household pay court-ordered ☐ **child support** ☐ **spousal support/alimony?** ☐ **Yes** ▶ ***If either of the boxes are checked above, complete the table below.*** ☐ **No**

Person paying	Court-order/docket number and county of order	Order amount	Amount paid	per	For whom
		$____	$ ____	☐ Week ☐ Month ☐ Other	
		$____	$ ____	☐ Week ☐ Month ☐ Other	
		$____	$ ____	☐ Week ☐ Month ☐ Other	

DHS-1171 (Rev. 10-11) Previous edition obsolete. P

EXHIBIT (PAGE 17)

Q. Medical Expenses

Do you need more pages? ☐ *Yes* ☐ *No*

1. List anyone who has paid or unpaid medical expenses for services provided in the last three months:

▸ Who?_____ What months?_____

List anyone who has paid medical premiums in the last three months:

▸ Who?_____ What months?_____

2. Does anyone in your household have any ongoing medical expenses?

☐ **Yes** ▸ ***Check all expenses that apply and complete the table below.*** ☐ **No**

☐ Medical care	☐ Prescribed over-the-counter drugs	☐ Service animal
☐ Dental care	☐ Prescription drugs	☐ Guardian/conservator fees
☐ Hospitalization	☐ Prescription drug card	☐ Health insurance premium
☐ Transportation for medical care (for pregnancy or ongoing care)	☐ Dentures	☐ Medicare premium
	☐ Eyeglasses	☐ Medical equipment/supplies
☐ Emergency room	☐ Hearing aids	☐ Personal care/chore services
☐ Nursing facility	☐ Prosthetics	☐ Other

Person with expense	Medical expense (checked above)	Amount person pays	How often (monthly, yearly, etc.)

R. Shelter Expenses

Check the boxes that apply and fill in the amount.*

1. ☐ Rent $ _____ (enter ONLY the amount you pay, NOT the amount paid by HUD, Section 8, MSHDA, etc.)
   ☐ Weekly ☐ Monthly ☐ Other
   ☐ Renter's insurance $_____ per year *(answer ONLY if applying for MA for a nursing facility)*
2. Does anyone pay for:
   Rent that includes meals (room/board) ☐ Yes ▸ $ _____ ☐ Weekly ☐ Monthly ☐ Other ☐ No
   Meals only (board) ☐ Yes ▸ $ _____ ☐ Weekly ☐ Monthly ☐ Other ☐ No
3. ☐ Mobile home lot rent? $ _____ ☐ Weekly ☐ Monthly ☐ Other
4. ☐ Mortgage/mobile home/land contract $ _____ ☐ Weekly ☐ Monthly ☐ Other
5. ☐ Second mortgage or home equity loan $ _____ ☐ Weekly ☐ Monthly ☐ Other
6. Shelter expenses billed separately from rent or mortgage: ☐ Fuel Type (Ex. wood, gas, propane) _____

☐ Heat (gas, electric, propane, wood, etc.)	☐ Homeowner's insurance $ _____ per year
☐ Cooling (including room air conditioner)	☐ Property taxes $ _____ per year
☐ Electricity (non-heat)	☐ Special assessments $_____per_____
☐ Water/sewer	☐ Mortgage guarantee insurance $ _____ per _____
☐ Cooking fuel	☐ Cooperative/condominium/association fee $_____
☐ Garbage/trash pick-up	☐ Other_____ $ _____
☐ Telephone	

7. **Michigan Department of Treasury Home Heating Credit (HHC)** - For the current fiscal year:
   a. Has anyone in your household who is applying for FAP received the HHC for the ***current address***?
      ☐ **Yes** ☐ **No**
   b. Will anyone in your household who is applying for FAP, apply or expect to apply for, the HHC for the ***current address***? ☐ **Yes** ☐ **No**

**If you are applying for medical assistance ONLY and you are in a nursing facility and have a spouse or dependent living at home, complete Section R. If you are applying for OTHER medical assistance ONLY, you may skip Section R.*

DHS-1171 (Rev. 10-11) Previous edition obsolete. Q

EXHIBIT (PAGE 18)

S. Receipt of Benefits

1. Did anyone in your household ever apply for or receive benefits from Michigan in the past? ☐ Yes ☐ No
   - If yes, under what name(s)? _____ (maiden name, alias, former spouse, etc.)
   - If yes, does anyone have a Bridge card? ☐ Yes ☐ No *For more information about these cards, see the **Information Booklet**.*
     If yes, who? _____
   - If yes, does anyone have a mihealth card? ☐ Yes ☐ No
     Who does not have a mihealth card? _____
2. Does anyone in your household receive Women, Infants, Children (WIC) benefits? ☐ Yes ☐ No
   - If yes, who? _____
3. Does anyone in your household receive tribal TANF (cash) benefits? ☐ Yes ☐ No
   - If yes, who? _____
4. Does anyone in your household receive Adoption subsidy/Guardianship Assistance Payments? ☐ Yes ☐ No
   - If yes, who? _____

T. Information DHS Needs to Know

Answer for everyone in your household.

- Has anyone ever been disqualified or had their benefits reduced or stopped because they did not follow program rules? ☐ Yes ☐ No
  - If yes, who? _____
- Has anyone ever been convicted of fraud for receiving cash or food assistance from two or more states for the same time period? ☐ Yes ☐ No
  - If yes, who? _____ What program(s)? _____
- Is anyone fleeing from felony prosecution or jail? ☐ Yes ☐ No
  - If yes, who? _____
- Has anyone ever been convicted of a drug-related felony occurring after August 22, 1996? ☐ Yes ☐ No
  - If yes, who? _____ Convicted more than once? ☐ Yes ☐ No
- Is anyone in violation of probation or parole? ☐ Yes ☐ No
  - If yes, who? _____

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EXHIBIT (PAGE 19)

U. State of Michigan Voter Registration Application

If you are not already registered to vote at your current address, would you like to register to vote? ☐ Yes ☐ No

NOTE: If you do not check either box, DHS will assume you have decided not to register to vote at this time.

Applying or declining to register to vote will not affect the amount of help that you will be provided by this department. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.

If you believe that someone has interfered with your right to:

- Register to vote.
- Decline to register to vote.
- Privacy in deciding whether to register or in applying to register to vote.
- Choose your own political party or other political preference.

You may file a complaint with:

Secretary of State
PO Box 20126
Lansing, MI 48901-0726

V. Representative, Guardian, Conservator or Person Helping with Application

1. If you are eligible for food assistance, do you want someone else to have a Bridge card and access to your food benefits to shop for you? ☐ Yes ☐ No

   If yes, enter his/her full name _____
   (This person will be your authorized representative.)

2. Are you filling this application out for someone else? ☐ Yes ☐ No
   Are you representing the person applying? ☐ Yes ☐ No
   Check one or both.

   ▸ ***If Yes is checked for one or both questions above, complete the following information:***

   Name | Phone number ___-___-____

   Street address (number, street, rural route, apartment/lot number, PO box)

   City | State | Zip code

   Representative's relationship to applicant *(check all that apply)*
   ☐ Guardian ☐ Relative (*specify*) _____
   ☐ Conservator ☐ Other (*specify*) _____

   If you are under age 18, are you married?
   ☐ Yes ☐ No

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EXHIBIT (PAGE 20)

W. Affidavit

IMPORTANT: Before you sign this application, READ the affidavit.

Under penalties of perjury, I swear or affirm that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this application has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

I certify that I have received a copy, reviewed and agree with the sections in the assistance application **Information Booklet** explaining how to apply for and receive help: Programs, Things You Must Do, Important Things to Know, Repay Agreements, and Information About Your Household That Will Be Shared.

I certify, under penalty of perjury, that all the information I have written on this form or told my DHS specialist or my representative is true. I understand I can be prosecuted for perjury if I have intentionally given false or misleading information, misrepresented, hidden or withheld facts that may cause me to receive assistance I should not receive or more assistance than I should receive. I can be prosecuted for fraud and/or be required to repay the amount wrongfully received. I understand I may be asked to show proof of any information I have given.

Signature of client or representative	Date	When in-person interview completed: Signature of department witness/migrant recruiter	Date

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EXHIBIT (PAGE 21)

Notes

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EXHIBIT (PAGE 22)

Notes

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MANUAL MAINTENANCE INSTRUCTIONS